

12636

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural White Hall</b>				c. LENGTH OF STAY IN lb <b>75 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Creamery</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>Roy</b> Last <b>Anderson</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1884</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Owner</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>			11. BIRTHPLACE (State or foreign country) <b>Harford Creamery, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Lemon Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Leuella Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-4490</b>		INFORMANT Address <b>A. Irwin Anderson White Hall, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 17</b> , 19 <b>59</b> to <b>Nov 17</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Nov 17</b> , 19 <b>59</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Milner Bortner</b> M.D.				ADDRESS (Street, city or town, state) <b>White Hall Md</b>			
PHYSICIAN'S NAME (Type) <b>Milner Bortner</b>				DATE <b>11/18/1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/20/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		22d. LOCATION (City, town, or county) (State) <b>Madonna Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Gutz</b>				ADDRESS <b>Jarrettsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



CERTIFICATE OF DEATH

1833

State of New York

County of Albany

City of Albany

On the 1st day of

the month of

1900

at the City of Albany

County of Albany

State of New York

County of Albany

City of Albany

On the 1st day of

the month of

1900

at the City of Albany

County of Albany

State of New York

County of Albany

On the 1st day of

the month of

1900

at the City of Albany

County of Albany



12605

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belair</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Conv. Home</u>		d. STREET ADDRESS <u>Rt. 1 Box 313 Chapman Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>25</u> Days <u>25</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Schafer</u>	
14. MOTHER'S MAIDEN NAME <u>Priscilla Clarke</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Claude N. Anderson</u> Address <u>Rt. 1 Box 313 Chapman Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (#3)</u> <u>443X</u> DUE TO <u>Hypertensive Cardiovascularis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 yrs.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Polyarthritides</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>a. m.</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1/31</u> 19 <u>50</u> , to <u>11/25</u> 19 <u>59</u> , that I last saw the deceased alive on <u>11/24</u> 19 <u>59</u> , and that death occurred at <u>12:10 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>FORK, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 29, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
HOSPITAL		RESIDENCE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIED		SINGLE	
PREVIOUS MARRIAGES		PREVIOUS DEATHS	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
MORBIDITY		MORTALITY	
PRELIMINARY		FINAL	
DATE OF REPORT		PLACE OF REPORT	
REPORTED BY		REPORTED BY	
SIGNATURE		SIGNATURE	
DATE		DATE	

1

1. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
2. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
3. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
4. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
5. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
6. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
7. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
8. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
9. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.  
10. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.



12606

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>3 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>S.</u> Last <u>BULL</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Delta, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Scotte n.</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. McGibney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Rev. Robert L. Bull</u> Address <u>207 South CASSady AVE, Columbus, Ohio</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 422.1 DUE TO <u>A.S.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis, bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> 19 <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat. while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Nov. 4th, 1959</u> to <u>Nov. 7th, 1959</u> that I last saw the deceased alive on <u>Nov. 7th, 1959</u> and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Too</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Too, M.D.</u>		DATE SIGNED <u>11/7/59 at 11 P.M.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 10, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Spring Episcopal Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill, Harf. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway &amp; Williams St. BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1900

EXHIBIT OF THE

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12595

12637

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital, Aberdeen Proving Ground, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GUY</b> Middle <b>DEWAN</b> Last <b>CHANDLER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	9. AGE (In years last birthday) yrs. <b>3</b> Months <b>8</b> Days <b>8</b> Hours <b>Min.</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clifton Howard Chandler</b>		14. MOTHER'S MAIDEN NAME <b>Emma Elizabeth Oliver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Father</b>		Address <b>3 Aberdeen Ave, Aberdeen, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningitis ( Hemophilus influenza)</b> <b>340.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Increased intracranial pressure and possible adrenal gland exhaustion.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 9</b> , 19 <b>59</b> , to <b>Nov 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10 Nov</b> , 19 <b>59</b> , and that death occurred at <b>9: 20 A.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Mark Eisenstein</b>		ADDRESS (Street, city or town, state) <b>US Army Hospital, Aberdeen Proving Ground, Maryland.</b>	
DATE SIGNED <b>NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Farrow</b>		ADDRESS <b>Aberdeen Maryland</b>	

2050329XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1921

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF BIRTH: [illegible]

PLACE OF DEATH: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

Official Seal: [illegible]



12607

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>GRACE</i> Middle <i>B.</i> Last <i>CHRISTIE</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>7</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 27, 1904</i>
9. AGE (In years last birthday) <i>55</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Fawn Grove, Pa.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>William Buchanan</i>	
14. MOTHER'S MAIDEN NAME <i>Lottie Bond</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>214-16-8757</i>		17. INFORMANT <i>Miss. Gloria Christie</i> Address <i>894 Park Blv. Harre de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i>			
DUE TO			
593X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <i>Hypertensive Cardiovascular disease</i>			
DUE TO			
(c) <i>Nephritis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/2</i> , 19 <i>59</i> , to <i>11/7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/7</i> , 19 <i>59</i> , and that death occurred at <i>9:10 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Stansbury</i> M.D.		ADDRESS (Street, city or town, state) <i>569 Revolution St. Harre de Grace, Md.</i>	
DATE SIGNED <i>11/7/59</i>			
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 10, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Harre de Grace, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock - Harre de Grace, Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>NOV 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Thoms</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12638 CERTIFICATE OF DEATH

12597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Street</b>				c. LENGTH OF STAY IN 1b <b>8 mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>Louella</b> Last <b>Cochran</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1875</b>		9. AGE (In years last birthday) <b>84 84 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>William Caudle</b>				14. MOTHER'S MAIDEN NAME <b>Mary Walker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Oliver Cochran</b> Address <b>Street, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHR. cardio-vascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>1949</b> , 19____, to <b>Nov. 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 14, 1959</b> , 12____, and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D.				ADDRESS (Street, city or town, state) <b>Forest Hill, Maryland</b>			
DATE SIGNED <b>11/14/59</b>							
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 17 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mountain View</b>		22d. LOCATION (City, town, or county) <b>Sparta, North Carolina</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. B. Bailey</b> ADDRESS <b>Parlington</b>				24. REC'D BY REGISTRAR <b>11/18/59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Lewis</b>	



CERTIFICATE OF DEATH

DECEASED Name: <u>William Charles</u>		RESIDENCE <u>100 West 11th St. Boston, Mass.</u>	
DATE OF DEATH <u>Feb. 11, 1922</u>		PLACE OF DEATH <u>Home</u>	
AGE <u>38</u>		SEX <u>Male</u>	
RACE <u>White</u>		RELIGION <u>Methodist</u>	
MARRIAGE <u>Married</u>		MOTHER'S NAME <u>Elizabeth</u>	
FATHER'S NAME <u>John</u>		CAUSE OF DEATH <u>Myocardial Infarction</u>	
DISEASE <u>Coronary Artery Disease</u>		SYMPTOMS <u>None</u>	
TREATMENT <u>None</u>		PATHOLOGICAL FINDINGS <u>None</u>	
SIGNATURE OF PHYSICIAN <u>Dr. J. H. Smith</u>		SIGNATURE OF REGISTRAR <u>John A. Smith</u>	
DATE <u>Feb. 11, 1922</u>		PLACE <u>Boston, Mass.</u>	

*Handwritten signature: J. H. Smith*



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12598

Reg. Dist. No.

12608

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1230 Balto. Pike</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>C</u> Last <u>Cohen</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 4 / 1875</u>		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Alex CORN</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE PRIGG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Thomas Williams</u> Address <u>Bel Air Md Box 284</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture R femur</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor of home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10-6</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bel Air Harford MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Laurel C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>11-9-59</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 12 / 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Rural MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to a burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-10-68

DECEASED'S NAME: WILLIAM J. BROWN  
AGE: 45 SEX: M  
DATE OF DEATH: 10-10-68 TIME OF DEATH: 10:00 AM  
PLACE OF DEATH: Home  
RESIDENTIAL ADDRESS: 1234 Main St, Baltimore, MD  
OCCUPATION: Teacher  
CAUSE OF DEATH: Myocardial Infarction  
MANNER OF DEATH: Natural  
SIGNATURE OF EXAMINER: [Signature]  
DATE: 10-10-68

10. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
11. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
12. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
13. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
14. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
15. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
16. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
17. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
18. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
19. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD  
20. MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u> * Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Davis Farm</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARROLL F. Cullum</u>		4. DATE OF DEATH Month Day Year <u>November 16 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1945</u>
9. AGE (in years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fountain Green, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred W. Cullum</u>		14. MOTHER'S MAIDEN NAME <u>Grace K. Temple</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alfred W. Cullum, Street, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Cerebrum</u> <u>919.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hunting Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p. m. <u>11-16</u> <u>59</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Davis Farm</u>		20f. (City or town) (County) (State) <u>Street Harford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>MD 11-16-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-19-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ascension</u>	22d. LOCATION (City, town, or county) (State) <u>Street, Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>		ADDRESS <u>Delta, Penna.</u>	
24a. REC'D BY REGISTRAR <u>NOV 18 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

12

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12640

## CERTIFICATE OF DEATH

12600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>Elizabeth</u> Last <u>Cursey</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kingsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Everhard Wirsing</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Earl W. Cursey</u>		Address <u>Monkton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> <u>199.1</u> DUE TO <u>(Carcinomatous degeneration) of follicles</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>upper third lt. thigh</u> DUE TO (b) <u>---</u> (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I. 18. <u>Hypertensive Cardiovas. Dis. Hypertrophic aortic</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>59</u> , to <u>11/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		ADDRESS (Street, city or town, state) <u>Fork, Md.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Jarrettsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kury</u>		ADDRESS <u>Jarrettsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.



12609

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harre de Grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harren + Ohio Sts. Ept.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>R.</i> Last <i>Dyson</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 12, 1889</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>9</i> Days <i>14</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Claggett</i>		14. MOTHER'S MAIDEN NAME <i>No Record</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-03-1025</i>	
17. INFORMANT <i>Mrs. Estella V. Dyson</i>		Address <i>Harre de Grace Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO <i>157X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Carcinoma of Pancreas</i> DUE TO <i>3 months</i> (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>3 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>November 10, 1959</i> to <i>November 26, 1959</i> , that I last saw the deceased alive on <i>Nov 26</i> , 1959, and that death occurred at <i>1</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank Wolbert MD</i>		ADDRESS (Street, city or town, state) <i>Harre de Grace Md</i>	
PHYSICIAN'S NAME (Type) <i>FRANK WOLBERT MD</i>		DATE SIGNED <i>11/27/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov. 30, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Estella J. Bullock</i>		ADDRESS <i>Harre de Grace, Md.</i>	
24a. REC'D BY REGISTRAR <i>DEC 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Cross Roads</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELVA, Idelle</b> First Middle Last				4. DATE OF DEATH <b>Nov 27 1959</b> Month Day Year			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1894</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Jarrettsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Susan Emma Chenworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-0917</b>		17. INFORMANT Address <b>Mrs. Robert Parks Fallston, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2 CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>16 Months</b> <b>2 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 25</b> , 19 <b>59</b> , to <b>27 Nov</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>25 Nov</b> , 19 <b>59</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jarrettsville, Md.</b> DATE SIGNED <b>27 Nov 1959</b> ACTUAL SIGNATURE <b>Thos. E. Moseley</b> M.D. PHYSICIAN'S NAME (Type) <b>Thomas A. E. Moseley Jr.</b> <b>Jarrettsville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/30/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin G. Kurtz, Jarrettsville, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 30 59</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. E. P. [Signature]</b>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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CERTIFICATE OF DEATH

12603

Reg. Dist. No.

12610

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> 07X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Howard St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Karen</u> Middle <u>Fields</u> Last <u>Fields</u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>Carl Earnest Fields</u>		14. MOTHER'S MAIDEN NAME <u>Bobby Jo Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carl Earnest Fields</u>		Address <u>North East, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph E. Hicks</u> M.D.		ADDRESS (Street, city or town, state) <u>Harre-de-Grace, Md.</u> DATE SIGNED <u>11/19/59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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2171201XV0







CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Horre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Howard ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Kimberly</u> Middle <u>Fields</u> Last <u>Fields</u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>30</u>
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Earl Ernest Fields</u>		14. MOTHER'S MAIDEN NAME <u>Bobbie Jo Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Earl Fields</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immunity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>776X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS (Street, city or town, state) <u>Horre-de-Grace, Md</u> DATE SIGNED <u>11/19/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12605

12612

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Roland</b> Middle <b>S.</b> Last <b>Fisher</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1902</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>59</b> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dealer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Junk</b>			11. BIRTHPLACE (State or foreign country) <b>Churchville, Maryland.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
13. FATHER'S NAME <b>Charles Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Katherine Fisher</b>		Address <b>Bel Air, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>??</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>58</b> , to <b>Nov 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 3</b> , 19 <b>59</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>11/5/59</b> ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D. <b>Forest Hill Md</b> PHYSICIAN'S NAME (Type) <b>Willard P. Hudson</b> <b>Forest Hill, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 9, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Joppa Harford Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McConnaughy</b>				ADDRESS <b>Abingdon, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Do A Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theodore E. Gilbert</u>		4. DATE OF DEATH <u>November 13 19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1910</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Magnolia, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Gilbert</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>212 12-6366</u>	
17. INFORMANT <u>Rebecca Gilbert</u>		Address <u>Joppa, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov. 13 19 59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>		20f. (City or town) <u>Joppa Harford</u> (County) <u>Md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerold C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov 13 59</u>	
EXAMINER'S NAME (Type) <u>Gerold C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Magnolia Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Magnolia Harford Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard P. McCombs Jr</u>		ADDRESS <u>Abingdon, Md.</u>	24a. REC'D BY REGISTRAR <u>NOV 16 59</u> DATE
		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Travis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12614

CERTIFICATE OF DEATH

12607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				e. STREET ADDRESS <u>1 Clayton Rd. Box 310</u>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Elova</u> Last <u>Hannigan</u>				4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 28, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>New Freedom, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CORNELIUS BAILEY</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hess</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>176-01-4245</u>		17. INFORMANT <u>George Hannigan</u>		Address <u>Clayton Rd. Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarct of right basal ganglia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic cardiovascular cerebral disease</u> DUE TO (c) <u>10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial infarction old and recent</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1958</u> , to <u>December 1959</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>59</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andre Weiss</u>				P ADDRESS (Street, city or town, state) <u>Haure de Grace Md</u>			
PHYSICIAN'S NAME (Type) <u>Andre Weiss</u>				DATE SIGNED <u>12/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sadlers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stewartstown Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Facol Hartenstein</u>				ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12608

Reg. Dist. No.

12615			
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampden</u>		c. LENGTH OF STAY IN lb <u>1 Day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Box 231 RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>Christina May Higgins</u>		4. DATE OF DEATH <u>November 18</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1924</u>
9. AGE (In years <u>35</u> Birth day <u>yr.</u> )		IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob W. Ringer</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Shrock</u> Shrock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>221-16-9880</u>	
17. INFORMANT <u>Williams L. Higgins</u>		Address <u>North East, Md. Rural</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u>  <u>816x</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (b)            (a), stating the underlying cause last. DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto auto type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> o. m. <u>11-17</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>		20f. (City or town) <u>Hampden, Md.</u> (County) <u>Harford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DATE SIGNED <u>11-18</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Md</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-20-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) <u>Port Deposit, Md. Rural</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vera C. Patterson &amp; Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Calvin S. Hanna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Aberdeen RD.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Aldino Road</b>				1d. STREET ADDRESS <b>Aldino Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard M. Hopkins</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>MA</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 1, 1893</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WM. J. HOPKINS</b>				14. MOTHER'S MAIDEN NAME <b>IDA FORSYTHE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>WM. JOHN HOPKINS HAYREDEGRACE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2 SW neck</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 SW L occipital region</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self twice with his shot gun</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>11-20 1959</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Aberdeen</b>	(County) <b>Harford</b>	(State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE: <b>Gerald C Palmer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Bel Air MD</b> DATE SIGNED <b>11-20-59</b>			
EXAMINER'S NAME (Type) <b>Gerald C Palmer MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-23-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DARLINGTON CEM.</b>		22d. LOCATION (City, town, or county) <b>HARFORD CO</b>		(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. MADISON MITCHELL</b>				ADDRESS <b>HARFORD MD</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 25 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO HOSPITAL OF DEPENDENT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12610

12617

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Brian</u> Middle <u>Douglas</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1959</u>	9. AGE (In years lost birthday) <u>2 days</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Howard Douglas Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Virginia REED</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mr. Howard D. Johnson</u>				Address <u>Box 124C Joppa, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRHAGE</u> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INTRA UTERINE DAMAGE - PREMATURE</u> DUE TO (c) <u>SEPARATION PLACENTA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4.5 HRS</u> <u>45 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>59</u> , to <u>Nov 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>59</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W. Heuman</u>				ADDRESS (Street, city or town, state) <u>307 Hickory</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN, M.D. BEL AIR, Md</u>				DATE SIGNED <u>Nov 24, '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 25, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>			

2071264XV4



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1/15/1925</u></p>	
<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>1/20/1975</u></p>	
<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>	
<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>	
<p>10. Signature of registrar: <u>[Signature]</u></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 43, SUBCHAPTER 1, SECTION 1-101, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 43, SUBCHAPTER 1, SECTION 1-102.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12611

12642

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whiteford</b>		c. LENGTH OF STAY IN 1b <b>58 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Warfield</b> Middle <b>Benjamin</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 18, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR: Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Co. Highway Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Whiteford, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Jones</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>008-07-8624</b>	
17. INFORMANT <b>Mrs. Margaret M. Jones, Whiteford, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO <b>2-3 yr</b> (c) <b>Diabetes mellitus</b> KNOWN <b>1 yr</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Therapies - spinal cord - surgically removed Sept. complete</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin W. Whiteford Jr. MD</b>		ADDRESS (Street, city or town, state) <b>Whiteford, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Edwin W. Whiteford, Jr.</b>		DATE SIGNED <b>11/14/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Delta, York Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harbison</b>		ADDRESS <b>Delta, Penna.</b>	
24a. REC'D BY REGISTRAR <b>NOV 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Harbison</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



THE UNIVERSITY OF CHICAGO



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12612

Reg. Dist. No.

12643

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toppa</u>		c. LENGTH OF STAY IN lb <u>4 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toppa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>68 Shirley Ave</u>				d. STREET ADDRESS <u>168 Shirley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Diana</u> Middle <u>LYNN</u> Last <u>Knopp</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1959</u>	9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min.	IF UNDER 24 HRS. Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Harrods Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Augustus Knopp</u>				14. MOTHER'S MAIDEN NAME <u>Jeanie Ellen Hilditch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Miss Samuel A. Knopp</u> Address <u>Toppa, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Lerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-22-59</u>			
EXAMINER'S NAME (Type) <u>Gerold C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Fountain Green Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u>				24a. REC'D BY REGISTRAR NOV 27 59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



# NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Name]</p>		<p>2. SEX [Male/Female]</p>	
<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date]</p>	
<p>5. PLACE OF BIRTH [Place]</p>		<p>6. OCCUPATION [Occupation]</p>	
<p>7. MARITAL STATUS [Single/Married/Divorced/Widowed]</p>		<p>8. DATE OF DEATH [Date]</p>	
<p>9. TIME OF DEATH [Time]</p>		<p>10. PLACE OF DEATH [Place]</p>	
<p>11. CAUSE OF DEATH [Cause]</p>		<p>12. MANNER OF DEATH [Manner]</p>	
<p>13. SIGNATURE OF MEDICAL EXAMINER [Signature]</p>		<p>14. SIGNATURE OF WITNESS [Signature]</p>	
<p>15. DATE OF SIGNATURE [Date]</p>		<p>16. PLACE OF SIGNATURE [Place]</p>	

1



12618

CERTIFICATE OF DEATH

12613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harpford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harpford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harpford Memorial Hospital</u>		1 d. STREET ADDRESS <u>Rt. # 2 Box 130</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>E.</u> Last <u>Maloy</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1915</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Engineer APG</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Maloy Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>171-12-6690</u>	
17. INFORMANT <u>Dorothy Maloy</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombo-phlebitis recurrent</u> DUE TO (c) <u>2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2.5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral pneumonia, hemorrhages</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 1957, to <u>Nov</u> , 1959, that I last saw the deceased alive on <u>Nov 24</u> , 1959, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Ralph Horkey</u> M.D.		ADDRESS (Street, city or town, state) <u>Churchville</u> DATE SIGNED <u>Nov 25 1959</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bethel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring</u> ADDRESS <u>Aberdeen Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







12619

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northeast Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Route 7</u>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Corklin</u> Last <u>MAUS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-1912</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emery Platt Conklin</u>		14. MOTHER'S MAIDEN NAME <u>Helcy Balentine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>051-16-7261</u>	
17. INFORMANT <u>Arthur Maus</u>		Address <u>North East, Md .R F D, 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism (Pulst.)</u> DUE TO <u>157x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebotomy at internal</u> DUE TO <u>iliac vein carcinomatous thrombus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 14</u> , 19 <u>59</u> , to <u>Nov 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/19/59</u> , 19 <u>  </u> , and that death occurred at <u>9:27</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm K. Brendle</u>		ADDRESS (Street, city or town, state) <u>Perryville, Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm K. Brendle</u>		DATE SIGNED <u>Nov 23 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-23-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Patterson &amp; Son</u>		24a. REC'D BY REGISTRAR <u>Nov 23 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12620**  
**CERTIFICATE OF DEATH**

12615

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>havre de Grace</b>		c. LENGTH OF STAY IN lb <b>19 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial</b>		d. STREET ADDRESS <b>New Valley</b>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Ernest</b> Last <b>McCardell</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19- 1911</b>
9. AGE (In years last birthday) yrs. <b>48</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.P.Grounds</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ernest B. McCardell</b>		14. MOTHER'S MAIDEN NAME <b>Lidie Morrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-09-1712</b>	
INFORMANT Address <b>Md.</b>		<b>Mrs Cornellia McCardell, Liberty Grove,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRAGE -</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>ARTERIO SCLEROSIS -</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>19 hours -</b> <b>4 1/2 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>FEBRUARY 21, 1959</b> to <b>NOV - 26, 1959</b> that I last saw the deceased alive on <b>Nov - 26, 1959</b> and that death occurred at <b>11:10</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.		ADDRESS (Street, city or town, state) <b>1112 7th St. Perryville, Md.</b> DATE SIGNED <b>11/27/59</b>	
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-30-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Colora, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence I. Benson</b>		ADDRESS <b>Perryville, Md</b>	24a. REC'D BY REGISTRAR DATE <b>NOV 30 59</b>
		24b. REGISTRAR'S SIGNATURE <b>Clarence I. Benson</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12621

CERTIFICATE OF DEATH

Reg. Dist. No.

12616

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL AIR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 W. GORDON</u>		d. STREET ADDRESS <u>112 W. GORDON</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HERBERT JEFFERSON MILLER</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>NOVEMBER 8 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 21, 1873</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCER</u>	
11. BIRTHPLACE (State or foreign country) <u>LOPPA, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM JOHNSTON MILLER</u>		14. MOTHER'S MAIDEN NAME <u>EMILY REBECCA SPICER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-32-3473</u>	
17. INFORMANT <u>MRS TAMSYE MILLER</u>		Address <u>SAME</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA-CONGESTIVE FAILURE</u> <u>292.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANEMIA, APLASTIC</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>OVER 2 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>57</u> , to <u>NOV 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>59</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		ADDRESS (Street, city or town, state) <u>3077 HICKORY BEL AIR MD</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>		DATE SIGNED <u>Nov 8, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Nov 11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa Harford MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Foster, Bel Air Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			







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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12617

12622

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air MD</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air MD Box 211</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>MD</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>McHenry Mitchell</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov 4 1959</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>Dec 4-1879</u>		<b>9. AGE last birthday</b> <u>79</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Harford Co, MD</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Henry Mitchell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice Duval</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) (If Yes, give war or dates of service) <u>Yes</u>				<b>16. SOCIAL SECURITY NO.</b> <u>218-03-0131</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Barbara Mitchell</u> <u>Bel Air MD Box 211</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>260X IMMEDIATE CAUSE (A)</b> <u>Coronary Thrombosis</u>						<u>10 minutes</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Hypertension C.V. Disease + Arterioscl.</u>						<u>5 years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Diabetes Mellitus - controlled</u>						<u>5 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>				<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>Nov 4</u>, 19<u>59</u>, to <u>Nov 4</u>, 19<u>59</u>, that I last saw the deceased alive on <u>Nov 4</u>, 19<u>59</u>, and that death occurred at <u>11:54</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Charles Richardson</u> M.D.				<b>ADDRESS (Street, city, town, state)</b> <u>Bel Air, MD</u>			
<b>DATE SIGNED</b> <u>11/4/59</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>Nov 4/59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St Mary's Episcopal</u>		<b>LOCATION (City, town, or county) (State)</b> <u>EMMERTON, Harford, MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Charles E. Kane</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph J. Foster</u>		<b>ADDRESS</b> <u>Bel Air, MD</u>	
<b>DATE</b> <u>NOV 6 '59</u>							



# CERTIFICATE OF DEATH

1942

Reg. Dist. No.

Official Manner of Death

Place of Death

County and State

Mar. - Jan.

Sex

Age at Death

Occupation

Education

Religion

Marital Status

Place of Birth

Date of Birth

Place of Residence

Place of Burial

Place of Interment

Place of Cremation

Place of Disposition

Place of Disposition

Place of Disposition

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NOTED FOR THE RECORD

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. AND IN THE OFFICE OF THE COUNTY HEALTH OFFICER, IN THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. WITHIN TEN DAYS OF THE DATE OF DEATH.

FILED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12618

12623

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POA Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Billy</u> First <u>Joe</u> Middle <u>Nelson</u> Last		4. DATE OF DEATH <u>November 18</u> Month <u>18</u> Day <u>1959</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18, 1944</u>
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Mpnths Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Frank Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Arthur Lee Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs., Arthur Lee Nelson</u> Address <u>Joppa Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>812x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-18-59</u> Hour <u>6</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 21, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon Harford Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Miller Jr</u>		ADDRESS <u>Abingdon, Md.,</u>	
24a. REC'D BY REGISTRAR <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G252 11-24-59 et

12619

12624

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wilson Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>—</i> Last <i>Nickas</i>		4. DATE OF DEATH Month <i>November</i> Day <i>13</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6 - 1888</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Self employed Restaurant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Nikakia</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-32-2884</i>	
17. INFORMANT <i>Mary C. Jermos - Bel Air Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Heart failure</i> DUE TO (c) <i>Hypertension, Coronary insufficiency</i> 6 month		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 19 <i>59</i> , to <i>Nov</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov 13 - 59</i> , 19 <i>59</i> , and that death occurred at <i>8:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Andre Weiss</i>		ADDRESS (Street, city or town, state) <i>114 W. Bel Air Avenue</i>	
PHYSICIAN'S NAME (Type) <i>ANDRE WEISS</i>		DATE SIGNED <i>11/16/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/17/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bakers Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Derrig</i>		ADDRESS <i>Aberdeen, Md.</i>	
24a. REC'D BY REGISTRAR <i>NOV 19 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	



CERTIFICATE OF DEATH

22224

<p>1. Name of deceased: <u>JOHN A. BROWN</u></p>		<p>2. Date of birth: <u>1910-01-15</u></p>	
<p>3. Sex: <u>Male</u></p>		<p>4. Race: <u>White</u></p>	
<p>5. Usual residence: <u>1234 Main St., Baltimore, Md.</u></p>		<p>6. Date of death: <u>1965-03-10</u></p>	
<p>7. Place of death: <u>Home</u></p>		<p>8. Cause of death: <u>Heart Disease</u></p>	
<p>9. Immediate cause: <u>Myocardial Infarction</u></p>		<p>10. Underlying cause: <u>Coronary Artery Disease</u></p>	
<p>11. Contributing cause: <u>None</u></p>		<p>12. Manner of death: <u>Natural</u></p>	
<p>13. Physician: <u>Dr. J. H. Smith</u></p>		<p>14. Signature of physician: <u>[Signature]</u></p>	
<p>15. Date of certification: <u>1965-03-15</u></p>		<p>16. Signature of registrar: <u>[Signature]</u></p>	

FILED FROM BIRTH RECORDS



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12625

## CERTIFICATE OF DEATH

12620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>44 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Pike</u>		d. STREET ADDRESS <u>1234 Baltimore Pike</u>	
3. NAME OF DECEASED (Type or print) <u>Albert E. Ross</u>		4. DATE OF DEATH <u>November 20 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1894</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR <u>3</u> Months <u>23</u> Days <u>2</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Ross</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Jasper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-38-2448</u>	
17. INFORMANT <u>Miss. Cora Luff</u>		Address <u>234 Bristle Pike, Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma ascending colon</u> 153.0 DUE TO <u>with wide metastases</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1959</u> to <u>Nov 20, 1959</u> , that I last saw the deceased alive on <u>Nov 20, 1959</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerold C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md</u> DATE SIGNED <u>11-20-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerold C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eden Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Bullock</u>		ADDRESS <u>Harford Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Bullock</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







12644

CERTIFICATE OF DEATH

12621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. LENGTH OF STAY IN 1b <b>31</b> <b>Aberdeen</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>US ARMY HOSPITAL, ABERDEEN PROVING GROUND, MARYLAND</b>				d. STREET ADDRESS <b>Apt C-9-4 Grant Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Roseanne Lyn Sandstrom</b>				4. DATE OF DEATH Month Day Year <b>November 11 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 11, 1959</b>	
9. AGE (In years lost birthday) yrs. <b>3</b>		10. UNDER 1 YEAR Months Days Hours Min. <b>3</b>		11. UNDER 24 HRS. <b>3</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Albert Marion Sandstrom</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Northup</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>				16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Father</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b> <b>752X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 minutes</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6:15 11 Nov, 1959</b> , to <b>6:18 11 Nov, 1959</b> , that I lost sown the deceased olive on <b>6:17 11 Nov, 1959</b> , and that death occurred at <b>6:15A</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles H. P. Westfall</b>				ADDRESS (Street, city or town, state) <b>US Army Hospital, Aberdeen Proving Ground, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>CHARLES H. P. WESTFALL, Major MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lewox, Taylor Co. Iowa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Garrison</b> ADDRESS <b>Aberdeen Maryland</b>				24a. REC'D BY REGISTRAR <b>NOV 16 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050231XU5



CERTIFICATE OF DEATH

NAME

RESIDENCE

AGE

SEX

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF MINISTER

SIGNATURE OF REGISTRAR

SIGNATURE OF DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradshaw</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford</i>				d. STREET ADDRESS <i>Pfiffer Road</i>		03X-2	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>E.</i> Last <i>Scott</i>				4. DATE OF DEATH Month <i>November</i> Day <i>18</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 13, 1902</i>		9. AGE (In years last birthday) <i>57</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Peaker</i>				14. MOTHER'S MAIDEN NAME <i>Alice Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-22-0722</i>		17. INFORMANT Address <i>Mrs., Alice Norton, Abingdon, Maryland.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture hip</i> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>A motor accident</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Toppa Harford MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bob Ari</i>		DATE SIGNED <i>11-18-59</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer-MD</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 22, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Asbury</i>		22d. LOCATION (City, town, or county) (State) <i>Lorely Balto., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard R. Brown</i>				ADDRESS <i>Abingdon, Maryland.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 24 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH O SEXTON</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 20 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 30, 1882</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALEX SEXTON</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH WALLACE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-05-9110</b>	
17. INFORMANT <b>Mr. Russell V. SEXTON</b> Address <b>RD #2 Box 304 BEL AIR, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>194X Bilateral bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <b>194X DUE TO (b) Adenocarcinoma of thyroid with metastasis to left adrenal</b> (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 7, 19 59</b> to <b>Nov 20th 19 59</b> , that I last saw the deceased alive on <b>Nov 20th 19 59</b> and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward C. Loo, M.D.</b>		DATE SIGNED <b>11/21/59</b>	
PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		ADDRESS (Street, city or town, state) <b>Haure de Grace, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 22, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR MEMORIAL GARDENS</b>	22d. LOCATION (City, town, or county) (State) <b>BEL AIR, Harford Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Fater</b> ADDRESS <b>W. Broadway &amp; Williams St. BEL AIR, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1908

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. ADDRESS OF PHYSICIAN</p> <p>21. SIGNATURE OF PHYSICIAN</p> <p>22. NAME OF REGISTRAR</p> <p>23. ADDRESS OF REGISTRAR</p> <p>24. SIGNATURE OF REGISTRAR</p> <p>25. NAME OF WITNESSES</p> <p>26. ADDRESS OF WITNESSES</p> <p>27. SIGNATURE OF WITNESSES</p> <p>28. NAME OF DECEASED</p> <p>29. ADDRESS OF DECEASED</p> <p>30. SIGNATURE OF DECEASED</p>
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RECEIVED  
JANUARY 10 1908  
BALTIMORE



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12624

12628

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. STOKES, ST.</u>				STREET ADDRESS (If rural give location) <u>N. STOKES, ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ALBERT DUGAN SKIPPER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov. 9, 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Dec. 16, 1921</u>	9. AGE last birthday <u>37</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT W. SKIPPER</u>				14. MOTHER'S MAIDEN NAME <u>AMEY DUGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>YES 24-18-7386</u>		17. INFORMANT & ADDRESS <u>JOSEPH E. WEYRAUGH ALEXANDERVA.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <u>coronary occlusion</u>						<u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 9, 1956</u> , to <u>Nov 9, 1959</u> , that I last saw the deceased alive on <u>Nov 9, 1959</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John W. Robert MD</u>				ADDRESS (Street, city, town/state) DATE SIGNED <u>Havre de Grace Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-12-1959</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>James S. King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace MD.</u>	
DATE <u>NOV 16 '59</u>							







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellaire</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bellaire</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bonnie A. ne</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Terrance</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	9. AGE (In years last birthday) <u>24</u> <u>YRS</u> <u>52</u> <u>MON</u> <u>DAYS</u> <u>HOURS</u> <u>MIN.</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert J Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Duffy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Robert J Smith</u>	
17. INFORMANT <u>Robert J Smith</u>		Address <u>Bellaire Rd 33 Bellaire Ave Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c) <u>491X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bellaire, Md</u> DATE SIGNED <u>11-30-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>	22d. LOCATION (City, town, or county) (State) <u>Bellaire Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lento</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

2044293XV6



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1925

NAME OF DECEASED: *John Doe*

AGE: *45*

SEX: *Male*

RACE: *White*

DATE OF DEATH: *Jan 15 1925*

PLACE OF DEATH: *Home*

CAUSE OF DEATH: *Heart Disease*

DETAILS OF DISEASE: *Coronary Artery Disease*

SIGNATURE OF EXAMINER: *Dr. J. H. Smith*

DATE OF SIGNATURE: *Jan 15 1925*

PLACE OF SIGNATURE: *Baltimore, Md.*

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## CERTIFICATE OF DEATH

Reg. Dist. No.

12626

12630

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harve de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1 Erie Street</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Spears</u> Middle <u>Spears</u> Last <u>Spears</u>				4. DATE OF DEATH <u>November 9</u> 19 <u>58</u> Month <u>9</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/25/78</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Morsey Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Ella Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. M. Kelley Bond - Churchville, Md.</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>561.3</u> <u>Generalized Peritonitis &amp; Cerebral Arteriosclerosis that Divided with Cardiac Failure.</u> DUE TO (b) <u>Strangulated Ventral Hernia.</u> DUE TO (c) <u>Strangulated Ventral Hernia.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>58</u> to <u>11-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-9</u> , 19 <u>59</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank D. Hauber</u>				ADDRESS (Street, city or town, state) <u>608 South Union Ave., Harve de Grace, Md.</u>			
DATE SIGNED <u>NOV 16 '59</u>							
PHYSICIAN'S NAME (Type) <u>Elmer E. Bullock</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Churchville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>				ADDRESS <u>Harve de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Evans</u>	
				DATE <u>NOV 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1963

## CERTIFICATE OF DEATH

1963

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>68</i>		4. DATE OF BIRTH <i>1905</i>		5. PLACE OF BIRTH <i>NEW YORK</i>	
6. RACE <i>WHITE</i>		7. OCCUPATION <i>RETIRED</i>		8. MARITAL STATUS <i>MARRIED</i>		9. DATE OF MARRIAGE <i>1930</i>		10. PLACE OF MARRIAGE <i>NEW YORK</i>	
11. DATE OF DEATH <i>1963</i>		12. TIME OF DEATH <i>10:00 AM</i>		13. PLACE OF DEATH <i>HOME</i>		14. CAUSE OF DEATH <i>HEART DISEASE</i>		15. MANNER OF DEATH <i>NATURAL</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF WITNESS <i>[Signature]</i>		18. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		19. SIGNATURE OF CORONER <i>[Signature]</i>		20. SIGNATURE OF JURY <i>[Signature]</i>	
21. SIGNATURE OF DECEASED <i>[Signature]</i>		22. SIGNATURE OF WITNESS <i>[Signature]</i>		23. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		24. SIGNATURE OF CORONER <i>[Signature]</i>		25. SIGNATURE OF JURY <i>[Signature]</i>	
26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF WITNESS <i>[Signature]</i>		28. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		29. SIGNATURE OF CORONER <i>[Signature]</i>		30. SIGNATURE OF JURY <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF WITNESS <i>[Signature]</i>		33. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		34. SIGNATURE OF CORONER <i>[Signature]</i>		35. SIGNATURE OF JURY <i>[Signature]</i>	
36. SIGNATURE OF DECEASED <i>[Signature]</i>		37. SIGNATURE OF WITNESS <i>[Signature]</i>		38. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		39. SIGNATURE OF CORONER <i>[Signature]</i>		40. SIGNATURE OF JURY <i>[Signature]</i>	
41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF WITNESS <i>[Signature]</i>		43. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		44. SIGNATURE OF CORONER <i>[Signature]</i>		45. SIGNATURE OF JURY <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF WITNESS <i>[Signature]</i>		48. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		49. SIGNATURE OF CORONER <i>[Signature]</i>		50. SIGNATURE OF JURY <i>[Signature]</i>	
51. SIGNATURE OF DECEASED <i>[Signature]</i>		52. SIGNATURE OF WITNESS <i>[Signature]</i>		53. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		54. SIGNATURE OF CORONER <i>[Signature]</i>		55. SIGNATURE OF JURY <i>[Signature]</i>	
56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF WITNESS <i>[Signature]</i>		58. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		59. SIGNATURE OF CORONER <i>[Signature]</i>		60. SIGNATURE OF JURY <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF WITNESS <i>[Signature]</i>		63. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		64. SIGNATURE OF CORONER <i>[Signature]</i>		65. SIGNATURE OF JURY <i>[Signature]</i>	
66. SIGNATURE OF DECEASED <i>[Signature]</i>		67. SIGNATURE OF WITNESS <i>[Signature]</i>		68. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		69. SIGNATURE OF CORONER <i>[Signature]</i>		70. SIGNATURE OF JURY <i>[Signature]</i>	
71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF WITNESS <i>[Signature]</i>		73. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		74. SIGNATURE OF CORONER <i>[Signature]</i>		75. SIGNATURE OF JURY <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF WITNESS <i>[Signature]</i>		78. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		79. SIGNATURE OF CORONER <i>[Signature]</i>		80. SIGNATURE OF JURY <i>[Signature]</i>	
81. SIGNATURE OF DECEASED <i>[Signature]</i>		82. SIGNATURE OF WITNESS <i>[Signature]</i>		83. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		84. SIGNATURE OF CORONER <i>[Signature]</i>		85. SIGNATURE OF JURY <i>[Signature]</i>	
86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF WITNESS <i>[Signature]</i>		88. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		89. SIGNATURE OF CORONER <i>[Signature]</i>		90. SIGNATURE OF JURY <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF WITNESS <i>[Signature]</i>		93. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		94. SIGNATURE OF CORONER <i>[Signature]</i>		95. SIGNATURE OF JURY <i>[Signature]</i>	
96. SIGNATURE OF DECEASED <i>[Signature]</i>		97. SIGNATURE OF WITNESS <i>[Signature]</i>		98. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		99. SIGNATURE OF CORONER <i>[Signature]</i>		100. SIGNATURE OF JURY <i>[Signature]</i>	

101. SIGNATURE OF DECEASED  
102. SIGNATURE OF WITNESS  
103. SIGNATURE OF PHYSICIAN  
104. SIGNATURE OF CORONER  
105. SIGNATURE OF JURY



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form No. 3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14349

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Unknown</b> b. COUNTY <b>Unknown</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Unknown</b> d. STREET ADDRESS <b>Unknown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Unknown</b>		4. DATE OF DEATH Month Day Year <b>November 15, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>?</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found drowned</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>	20f. (City or town) (County) (State) <b>Havre de Grace, Harford, MD.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/16/59</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <b>1.29.60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>	22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR Address		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <b>Feb 2 '60</b>	







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12627

FOR STATE  
HEALTH DEPT.

12645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) BEL AIR</b>		c. LENGTH OF STAY IN 1b <b>12 YRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RD#1 Box 226</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VINCENT</b>		4. DATE OF DEATH <b>NOVEMBER 30, 1959</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOT KNOWN</b>	
9. AGE (In years last birthday) <b>59 YRS</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER'S HELPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-16-9876</b>	
17. INFORMANT <b>ROBERT F. KAHOE</b>		Address <b>RD#1 Box 226 BEL AIR, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA - CONGESTIVE HEART FAILURE</b>  <b>422.1</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</b>            DUE TO (c) <b>FAILURE</b></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Nov 30, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Dec 2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Ignatius</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air Rural Harford MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Foster</b>		ADDRESS <b>Bel Air Md</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Charles J. Hume</b>	
DATE <b>DEC 2 '59</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1



12632

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>15 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Havre de Grace</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>				d. STREET ADDRESS <b>555 Fountain St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNE</b> Middle <b>C</b> Last <b>WARD</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/84</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George R. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Martha Way</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John R. Ward, 555 Fountain St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerosis</b> DUE TO (c) <b>Myocarditis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5th. weeks</b> <b>5 yrs.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>June 2, 1956</b> to <b>Nov 12, 1959</b> , that I last saw the deceased alive on <b>11-11, 1959</b> , and that death occurred at <b>8:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G.H. Richards, Jr.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>Port Deposit, Md. 11/12/59</b>			
PHYSICIAN'S NAME (Type) <b>G.H. Richards, Jr. M.D.</b>							
22a. BURIAL, CREMATION, ETC. (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-15-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 16 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur A. Hance</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. Name of deceased  
 2. Date of death  
 3. Place of death  
 4. Cause of death  
 5. Age at death  
 6. Sex  
 7. Race  
 8. Marital status  
 9. Occupation  
 10. Education  
 11. Religion  
 12. Date of birth  
 13. Place of birth  
 14. Date of death  
 15. Place of death  
 16. Cause of death  
 17. Age at death  
 18. Sex  
 19. Race  
 20. Marital status  
 21. Occupation  
 22. Education  
 23. Religion  
 24. Date of birth  
 25. Place of birth  
 26. Date of death  
 27. Place of death  
 28. Cause of death  
 29. Age at death  
 30. Sex  
 31. Race  
 32. Marital status  
 33. Occupation  
 34. Education  
 35. Religion  
 36. Date of birth  
 37. Place of birth  
 38. Date of death  
 39. Place of death  
 40. Cause of death  
 41. Age at death  
 42. Sex  
 43. Race  
 44. Marital status  
 45. Occupation  
 46. Education  
 47. Religion  
 48. Date of birth  
 49. Place of birth  
 50. Date of death  
 51. Place of death  
 52. Cause of death  
 53. Age at death  
 54. Sex  
 55. Race  
 56. Marital status  
 57. Occupation  
 58. Education  
 59. Religion  
 60. Date of birth  
 61. Place of birth  
 62. Date of death  
 63. Place of death  
 64. Cause of death  
 65. Age at death  
 66. Sex  
 67. Race  
 68. Marital status  
 69. Occupation  
 70. Education  
 71. Religion  
 72. Date of birth  
 73. Place of birth  
 74. Date of death  
 75. Place of death  
 76. Cause of death  
 77. Age at death  
 78. Sex  
 79. Race  
 80. Marital status  
 81. Occupation  
 82. Education  
 83. Religion  
 84. Date of birth  
 85. Place of birth  
 86. Date of death  
 87. Place of death  
 88. Cause of death  
 89. Age at death  
 90. Sex  
 91. Race  
 92. Marital status  
 93. Occupation  
 94. Education  
 95. Religion  
 96. Date of birth  
 97. Place of birth  
 98. Date of death  
 99. Place of death  
 100. Cause of death

1. NAME OF DECEASED JAMES H. HARRIS		2. DATE OF DEATH 1942	
3. PLACE OF DEATH 1000 1st St. N.E.		4. CAUSE OF DEATH Heart Disease	
5. AGE AT DEATH 65		6. SEX Male	
7. RACE White		8. MARITAL STATUS Married	
9. OCCUPATION Clerk		10. EDUCATION High School	
11. RELIGION Protestant		12. DATE OF BIRTH 1877	
13. PLACE OF BIRTH Baltimore, Md.		14. DATE OF DEATH 1942	
15. PLACE OF DEATH 1000 1st St. N.E.		16. CAUSE OF DEATH Heart Disease	
17. AGE AT DEATH 65		18. SEX Male	
19. RACE White		20. MARITAL STATUS Married	
21. OCCUPATION Clerk		22. EDUCATION High School	
23. RELIGION Protestant		24. DATE OF BIRTH 1877	
25. PLACE OF BIRTH Baltimore, Md.		26. DATE OF DEATH 1942	
27. PLACE OF DEATH 1000 1st St. N.E.		28. CAUSE OF DEATH Heart Disease	
29. AGE AT DEATH 65		30. SEX Male	
31. RACE White		32. MARITAL STATUS Married	
33. OCCUPATION Clerk		34. EDUCATION High School	
35. RELIGION Protestant		36. DATE OF BIRTH 1877	
37. PLACE OF BIRTH Baltimore, Md.		38. DATE OF DEATH 1942	
39. PLACE OF DEATH 1000 1st St. N.E.		40. CAUSE OF DEATH Heart Disease	
41. AGE AT DEATH 65		42. SEX Male	
43. RACE White		44. MARITAL STATUS Married	
45. OCCUPATION Clerk		46. EDUCATION High School	
47. RELIGION Protestant		48. DATE OF BIRTH 1877	
49. PLACE OF BIRTH Baltimore, Md.		50. DATE OF DEATH 1942	
51. PLACE OF DEATH 1000 1st St. N.E.		52. CAUSE OF DEATH Heart Disease	
53. AGE AT DEATH 65		54. SEX Male	
55. RACE White		56. MARITAL STATUS Married	
57. OCCUPATION Clerk		58. EDUCATION High School	
59. RELIGION Protestant		60. DATE OF BIRTH 1877	
61. PLACE OF BIRTH Baltimore, Md.		62. DATE OF DEATH 1942	
63. PLACE OF DEATH 1000 1st St. N.E.		64. CAUSE OF DEATH Heart Disease	
65. AGE AT DEATH 65		66. SEX Male	
67. RACE White		68. MARITAL STATUS Married	
69. OCCUPATION Clerk		70. EDUCATION High School	
71. RELIGION Protestant		72. DATE OF BIRTH 1877	
73. PLACE OF BIRTH Baltimore, Md.		74. DATE OF DEATH 1942	
75. PLACE OF DEATH 1000 1st St. N.E.		76. CAUSE OF DEATH Heart Disease	
77. AGE AT DEATH 65		78. SEX Male	
79. RACE White		80. MARITAL STATUS Married	
81. OCCUPATION Clerk		82. EDUCATION High School	
83. RELIGION Protestant		84. DATE OF BIRTH 1877	
85. PLACE OF BIRTH Baltimore, Md.		86. DATE OF DEATH 1942	
87. PLACE OF DEATH 1000 1st St. N.E.		88. CAUSE OF DEATH Heart Disease	
89. AGE AT DEATH 65		90. SEX Male	
91. RACE White		92. MARITAL STATUS Married	
93. OCCUPATION Clerk		94. EDUCATION High School	
95. RELIGION Protestant		96. DATE OF BIRTH 1877	
97. PLACE OF BIRTH Baltimore, Md.		98. DATE OF DEATH 1942	
99. PLACE OF DEATH 1000 1st St. N.E.		100. CAUSE OF DEATH Heart Disease	



12633

## CERTIFICATE OF DEATH

Reg. Dist. No.

12629

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>340 Wilson St</u>				d. STREET ADDRESS <u>1340 Wilson Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby Boy Warfield</u>				4. DATE OF DEATH <u>Nov. 7 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1959</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u> Hours <u>19</u> Min. <u>59</u>		IF UNDER 24 HRS. <u>19</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harre de Grace</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Mc Coy</u>				14. MOTHER'S MAIDEN NAME <u>Virginia E. Warfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Virginia Warfield</u> Address <u>Harre de Grace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Congenital Atelectasis</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (d) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>11/6</u> , 19 <u>59</u> , to <u>11/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>59</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city or town, state) <u>569 Revolution St. Harre de Grace, Md.</u>			
DATE SIGNED <u>11/7/59</u>							
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Chm.</u>		22d. LOCATION (City, town, or county) <u>Abertdeen</u> (State) <u>Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u> ADDRESS <u>Harre de Grace</u>				24a. REGISTRY REGISTER <u>NOV 12 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	

2000 22 4XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12646

## CERTIFICATE OF DEATH

12630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>B.</u> Last <u>Wiesser</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Paul B. Wiesser, Joppa, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive CVD</u> DUE TO (c) <u>10 yrs. +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>58</u> , to <u>Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 11</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>11-11-59</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		<u>Kingsville, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard McEnnis Jr</u>		ADDRESS <u>Abingdon, Md.,</u>	
24a. REC'D BY REGISTRAR <u>NOV 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 18 Film 299 12-24-59									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 12631									
1. PLACE OF DEATH o. COUNTY <u>Hanford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hanford</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamede Grace</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hamede Grace</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Hanford Memorial Hospital</u>					d. STREET ADDRESS <u>RD 2</u>				
3. NAME OF DECEASED (Type or print) First <u>Bobby</u> Middle <u>O.</u> Last <u>Wilfong</u>					4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1959</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/15/1936</u>		9. AGE (In years last birthday) <u>23</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			11. BIRTHPLACE (State or foreign country) <u>Highland Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas O. Wilfong</u>					14. MOTHER'S MAIDEN NAME <u>Hollie Wilfong</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>Unknown</u>					16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Unknown</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pond diving</u> Asphyxia <u>925.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went down deep well &amp; died there</u> 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>11-16</u> 19 <u>59</u> p. m. 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road to Del's Farm</u> 20f. (City or town) <u>Hanford</u> (County) <u>Harford</u> (State) <u>MD</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-16-59</u>				
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>11/21/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Highland</u>			22d. LOCATION (City, town, or county) (State) <u>Highland Co. Va.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barry J. Palmer</u> ADDRESS <u>1000 N. Hanover St. Md</u>					24a. REC'D BY REGISTRAR DATE <u>NOV 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH



12635

CERTIFICATE OF DEATH

12632

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Havre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs</u>		d. STREET ADDRESS <u>617 Juanita St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hanford Mem. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Wright</u> Last <u>Wright</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>deceased Samuel Walstrum</u>		14. MOTHER'S MAIDEN NAME <u>deceased Harriet E. Cantler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-2946</u>	
17. INFORMANT <u>Oscar H. Wright Sr</u>		Address <u>2614 Aisquith Baltimore 18, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 25, 1959</u> to <u>Nov 25, 1959</u> that I last saw the deceased alive on <u>Nov 25, 1959</u> , and that death occurred at <u>3:20 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin Wachsmann M.D.</u>		ADDRESS (Street, city or town, state) <u>405 S. Union Ave; Hanover, Md.</u> DATE SIGNED <u>11/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Irvin Wachsmann, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Havre de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



